Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

TROPHY CLUB MEDICAL CENTER
2850 EAST STATE HIGHWAY 114
TROPHY CLUB TX 76262

Carrier's Austin Representative Box
Box Number 47

Respondent Name
TWIN CITY FIRE INSURANCE CO

MFDR Date Received
April 9, 2012

MFDR Tracking Number
M4-12-2561-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Implants not paid at Cost plus 10% per fee schedule Appeal submitted 09/15/11 original decision maintained"

Amount in Dispute: $18,992.53

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "provider did not include a certification for the amount billed in accordance with Rule 134.404 (g) (1)."

Response Submitted by: The Hartford, 300 South State St., Syracuse, NY 13202

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 15, 2011 To May 23, 2011	Inpatient Hospital Surgical Services	$18,992.53	$18,626.28

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.404 sets out the guidelines for reimbursement of hospital facility fees for inpatient services.
3. 28 Texas Administrative Code §134.404(e) states that: "Except as provided in subsection (h) of this section, regardless of billed amount, reimbursement shall be:

   (1) the amount for the service that is included in a specific fee schedule set in a contract that complies with the requirements of Labor Code §413.011; or

(2) if no contracted fee schedule exists that complies with Labor Code §413.011, the maximum allowable reimbursement (MAR) amount under subsection (f) of this section, including any applicable outlier payment amounts and reimbursement for implantables."

(3) If no contracted fee schedule exists that complies with Labor Code §413.011, and an amount cannot be determined by application of the formula to calculate the MAR as outlined in subsection (f) of this section, reimbursement shall be determined in accordance with §134.1 of this title (relating to Medical Reimbursement).

4. 28 Texas Administrative Code §134.404(f) states that "The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Inpatient Prospective Payment System (IPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:
   (A) 143 percent; unless
   (B) a facility or surgical implant provider requests separate reimbursement in accordance with subsection (g) of this section, in which case the facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 108 percent."

5. 28 Texas Administrative Code §134.404(g) states that "Implantables, when billed separately by the facility or a surgical implant provider in accordance with subsection (f)(1)(B) of this section, shall be reimbursed at the lesser of the manufacturer's invoice amount or the net amount (exclusive of rebates and discounts) plus 10 percent or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission."

6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated August 16, 2011
   - W1 — WORKERS' COMPENSATION STATE FEE SCHEDULE ADJUSTMENT. RE-PRICING INCLUDED IN THE DRG RATE.
   - 16 — CLAIM/SERV LACKS INFO WHICH IS NEEDED FOR ADJUDICATION. IN ORDER TO REVIEW THIS CHARGE WE NEED A COPY OF THE INVOICE DETAILING THE COST TO THE PROVIDER.

   Explanation of benefits dated November 4, 2011
   - 217 — BASED ON PAYER REASONABLE & CUSTOMARY FEES. REIMBURSEMENT MADE BASED ON INS CARRIER FAIR AND REASONABLE REIMBURSEMENT METHODOLOGY. CHARGES DISCOUNTED PER REVIEW BY QMEDTRIX. PLS CALL QMEDTRIX @ 1-800-833-1993 FOR QUESTIONS.

Issues

1. Is the respondent's denial reason code "16" supported?
2. Is the respondent's assertion that the requestor did not request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g) supported?
3. Can the maximum allowable reimbursement (MAR) amount for the disputed services be determined according to 28 Texas Administrative Code §134.404(f)?
4. Did the facility or a surgical implant provider request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g)?
5. Is the requestor entitled to additional reimbursement for the disputed services?

Findings

1. The respondent denied reimbursement based upon claim/service lacks information needed for adjudication. 28 TAC §133.3 requires that "Any communication between the health care provider and insurance carrier related to medical bill processing shall be of sufficient, specific detail to allow the respondent to easily identify the information required to resolve the issue or question related to the medical bill. Generic statements that simply state a conclusion such as 'insurance carrier improperly reduced the bill' or 'health care provider did not document" or other similar phrases with no further description of the factual basis for the sender's position does not satisfy the requirements of this section." The Division finds no documentation to support communication of sufficient, specific detail to allow the responder to easily identify the information required to resolve the issue or question related to the medical bill. For this reason, the Division finds that the 16 claim adjustment code is not supported. Therefore, the disputed services will be reviewed per applicable Division rules and fee guidelines.

2. It is the respondent's assertion in their response to the request for medical dispute resolution that the requestor did not request separate reimbursement for implantables in accordance with 28 Texas Administrative Code §134.404(g). Review of the requestor's submitted documentation finds that separate reimbursement for implantables was requested in accordance with 28 Texas Administrative Code §134.404(g). For this reason, the Division finds that the 16 claim adjustment code is not supported. Therefore, the disputed services will be reviewed per applicable Division rules and fee guidelines.
3. Review of the submitted documentation finds that the maximum allowable reimbursement (MAR) amount for the disputed services can be determined according to 28 Texas Administrative Code §134.404(f).
4. Review of the submitted documentation finds that separate reimbursement for implantables was requested in accordance with 28 Texas Administrative Code §134.404(g).
5. The Division finds the total allowable for implantables billed under revenue code 278 is:

Description of Implant per Itemized Statement	Quantity	Amt Billed	Invoice Cost	Cost + 10%
CoRoent XLT, 10x16x25mm	1	$6,202.00	$6,202.00	$6,202.00 + $620.20 =$6,822.20
Temporary Fixation Pin	2	$500.00	$250.00/each	$250.00 + $25.00 = $275.00 x 2 = $550.00
28mm/Level ACPS	1	$2,000.00	$2,000.00	$2,000.00 + $200.00 =$2,200.00
Locking Tab	3	$450.00	$150.00/each	$150.00 + $15.00 = $165.00 x 3 = $495.00
Allo Stem Morsalized	2	$4,000.00	$2,000.00/each	$2,000.00 + $200.00 =$2,200.00 x 2 = $4,400.00
Novabone Putty, 1cc	1	$499.00	$499.00	$499.00 + $49.90 = $548.90
Cancellous, Crushed	1	$115.00	$115.00	$115.00 + $11.50 = $126.50
18mmx4.3FT	4	$2,800.00	$700.00/each	$700.00 + $70.00 = $770.00 x 4 = $3,080.00
Closure/Hemostasis Device	2	$332.92	No Invoice Submitted/Item Unidentifiable	$0.00
Floseal Hemo Maxtrix 5ml, 6/cs	2	$367.00	$183.49/each	$183.49 + $18.35 = $201.84 x 2 = $403.68
TOTAL DUE				$18,626.28

6. Reimbursement for the disputed services is calculated in accordance with 28 TAC §134.404(f)(1)(B) as follows: The Medicare facility-specific reimbursement amount including outlier payment amount for DRG 458 is $27,084.39. This amount multiplied by 108% is $29,251.14.The total net invoice amount (exclusive of rebates and discounts) for the disputed implantables is $16,932.98. The total add-on amount of 10% or $1,000 per billed item add-on, whichever is less, but not to exceed $2,000 in add-on's per admission is $1,693.30. The total maximum allowable reimbursement (MAR) is therefore $47,877.42. The respondent previously paid $29,251.14, therefore an additional amount of $18,626.28 is recommended for payment.

Conclusion

For the reasons stated above, the division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $18, 626.28.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $18, 626.28 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	June 20, 2012 Date
Signature	Medical Fee Dispute Resolution Auditor III	June 20, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.